Questions and Answers about C. P. S.

Question: What action should I take if a C.P.S. patient does not signify his C.P.S. membership until after I have billed him for services rendered?

Answer: You should bill C.P.S. as soon as the fact of the patient's membership becomes known. In any case, all bills must be submitted to C.P.S. within six months from the end of the month in which service was rendered. (Note: The C.P.S. Physician Relations Department furnishes small attractive desk plaques for doctors' offices on which is printed the reminder that patients should present C.P.S. membership cards on the first visit.)

Question: Does C.P.S. pay additional fees for post-operative care?

Answer: (a) If there is a "T" after the fee payment in the Fee Schedule, there is no additional fee for after visits, unless exceptional complications develop.

(b) If there is an asterisk (*) after the fee payment in the Fee Schedule the fee is only for the primary procedure, and all after visits are paid for additionally by C.P.S.

(c) If there is no mark on the Fee Schedule, the fee includes two weeks' after-care and C.P.S. pays for necessary after visits beyond that time.

Question: If a C.P.S. patient who has Two-Visit Deductible medical coverage has paid for the first two visits to one doctor and is referred by that doctor to a second doctor for treatment of the same ailment, is the patient again responsible for the first two visits?

Answer: No. Holders of Two-Visit Deductible medical coverage are responsible for only the first two visits for each ailment, even though they may be referred to a second doctor. (Note: All referrals should be indicated on the billing form.) However, if the patient changes of his own accord, he is again responsible for the first two visits.

Question: How do I handle the veteran who comes to my office and *demands immediate treatment?*

Answer: By telling him that the V.A. will not pay for visits made before authorization is issued and that, therefore, you must bill him as a private patient until authorization is received.

In actual emergencies, authorization may be secured by telephone to either the San Francisco or Los Angeles C.P.S.-Veterans offices after service connection has been established.

Question: After a veteran's case has been established as service-connected, and I have authority to treat him, why must I ask for a new authority every month?

Answer: Because to pay for every authorization issued, actual money must be encumbered in advance in the budget for that period, and funds must be ear-marked in advance for payment of each subsequent authorization as treatment progresses.

Question: May I bill C.P.S. patients for any difference between the C.P.S. fee and my regular charge?

Answer: The answer depends on whether the patient's income is over or under the income ceiling. Under terms of physician-members' membership in C.P.S., if income is under the ceiling, they *may not* charge the difference between the C.P.S. fee and their usual fee. If income is over the ceiling, doctors are entitled to charge the difference between fees. The income ceiling also applies to x-ray and laboratory services. (Note: The income ceiling for all C.P.S. members, except Grange members, is $3,600 annual gross family income from all sources, for the preceding calendar year. For Grange members it is $3,600 *net* family income as computed for Federal income tax for 1949.)

Question: Are payments for routine physical examinations or check-ups provided under any C.P.S. contract?

Answer: No, because C.P.S. covers only active illnesses and injuries.

Question: This being vacation time, some of my patients ask me if their C.P.S. benefits extend outside California. What is the rule on this?

Answer: C.P.S. benefits are available anywhere in the world. For members who are traveling or temporarily residing outside California, C.P.S. will pay up to the amount paid to California physician-members and hospitals for like services, provided the services have been rendered by a licensed physician, surgeon or hospital. Patients should pay the bill and then claim reimbursement from C.P.S., submitting the receipted bill with the claim.

Question: What is the interpretation of the "three months' chronic condition clause" as regards the period during which a C.P.S. patient is eligible for treatment of a chronic condition?

Answer: The interpretation of this clause is that the patient is entitled to three *consecutive* months' treatment for a chronic condition. In other words, contract benefits for a chronic ailment expire three months after the date that the patient first utilizes his C.P.S. coverage for that condition, regardless of the amount of treatment received during the three months. The clause does not mean three months' care at broken intervals.

Question: What surgical treatment, if any, can be given a veteran under the C.P.S.-V.A. Home Town Medical Care Plan?

Answer: Only minor operations which have been authorized by V.A. and can be performed safely in the doctor's office, or on a "come and go" basis in a hospital. "Come and go" means use of minor operating room facilities in the outpatient department and less than an overnight stay with no meals served. The condition must be service-connected.